Atlantic
Health System
Morristown Medical Center

RADIATION ONCOLOGY DEPARTMENT
INSURANCE COVERAGE AND PATIENT RESPONSIBILITY

Dear Patient,

We know that dealing with insurance companies and medical bills is not pleasant, but we want you to receive the best possible service available and have taken steps to provide courteous and knowledgeable people who will help you.

With the breakthrough of new technologies, you may need to verify coverage with your healthcare provider. Radiation therapy requires very complex equipment and the services of many healthcare professionals. The exact cost of your radiation treatment depends upon the type and number of treatments needed.

As there are many different insurance programs, it is difficult to know the details of each plan. In order to determine what services are covered with your individual policy, it will be your responsibility to check with your insurance company. Most health insurance policies, including Part B of Medicare, cover charges for radiation therapy. Should a referral be needed for treatment, please bring it with you at the time of your initial consultation visit. We will inform you if additional referrals are needed for treatment. Our contact person in Radiation Oncology Department is here to help you with any questions you may have and may be reached at 973-971-5674.

Please be aware that you will be receiving two separate bills.

- One part of the bill will be from the physician's billing company, Atlantic Medical Group for professional fees. Should you have any questions regarding this portion of your bill, please call 973-656-6295.
- The second part of the bill will be from Morristown Medical Center for technical and facility charges. If you should have questions regarding this portion of your bill, please call 1-800-619-4024.

Certain high-priced imaging studies, such as CT, MRI, PET or bone scans, may require authorization from your plan before they can be performed. Please make sure that we are aware of any lab and/or x-ray clauses in your policy that require you to have these tests performed at another facility. Please be sure to inform us at the time of scheduling if authorization is necessary.

I have read the above and fully understand my responsibilities.

Signed:_____ Date:_____
Patient or Responsible Party

100 Madison Avenue
Morristown, NJ 07962